

Abstracts

329

CONCLUSIONS: The EQ-5D was easily understood and accepted by this cohort of patients with ACS and can serve as a valid measure of health-related quality of life in ACS population-based studies.

PCV36

THE IMPACT OF ACEI RELATED COUGH: A SURVEY OF AUSTRALIAN PATIENTS

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OBJECTIVES: Cough is a widely recognised adverse effect of Angiotensin-converting enzyme inhibitors (ACEI) and has been linked to poor medication compliance and potentially poorer quality of life (QoL). Clinically, AIIRAs (Angiotensin II receptor antagonists) have been shown to reduce the occurrence of cough relative to ACEIs. This study was designed to determine the impact of cough on patients' QoL by using generic and cough-specific QoL measures and contingent valuation (CV) methodology. **METHODS:** Ninety-one patients currently on ACEIs and 48 patients switched from ACEIs to AIIRAs were recruited from across Australia. Both groups were asked to complete the World Health Organisation Quality of Life questionnaire (brief version) (WHOQoL-Bref) and to answer general questions on QoL, health and demographics. Those on ACEIs also completed the Cough-specific Quality of Life Questionnaire (CQLQ). A CV question, which gave the participants the choice between an ACEI and AIIRA level of cough, was also asked. The CV health states were based on clinical trial data. **RESULTS:** Respondents ranged in age from 38–81 years (mean = 58.4 years) in the ACEI group, and 31–82 years (mean = 55.6 years) in the AIIRA group. A significant relationship between cough severity and QoL existed for the CQLQ ($p = 0.003$) and the WHOQoL-Bref ($p = 0.025$) in the ACEI group. Cough severity was significantly related to difficulty of sleeping ($p = 0.009$), being self-conscious ($p = 0.015$), and exhaustion ($p = 0.002$). The CV analysis for the AIIRA scenario yielded a mean willingness-to-pay of AUS\$16.80 per month for those on ACEIs and AUS\$16.20 per month for those on AIIRAs. **CONCLUSION:** Overall, the results from this study illustrate the impact that ACEI-induced cough has on quality of life. Both patient groups were willing to pay over AUS\$16 per month to experience effective hypertension control associated with a lower risk of experiencing cough. This suggests that the impact of cough on QoL may be more than previously considered and should be considered when selecting anti-hypertensive treatment.

PCV37

HEALTH-RELATED QUALITY OF LIFE OF PATIENTS MAKING AN ATTEMPT AT SMOKING CESSATION

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OBJECTIVE: To assess the acute effects of smoking cessation on health-related quality of life (HQL). **METHODS:** Questionnaires were mailed to patients enrolled in a smoking-cessation program just prior to quit date (T1) and 1-week post-quit (T2). HQL was assessed by the Smoking Cessation Quality of Life Questionnaire (SCQoLQ). It contains 5 cessation-targeted scales: social interactions, self-control, sleep, cognitive-functioning, and anxiety. The SF-36 is included as a generic core. Other data

included patient demographics, duration of smoking, Fagerstrom scale, and smoking status at T2. Student's t-test for paired data was used to compare the T1–T2 HQL scores. Student's t-test for independent samples compared the HQL of a higher addiction (HA) group (Fagerstrom > 6) to a lower addiction (LA) group (Fagerstrom ≤ 6). **RESULTS:** Respondents ($n = 34$, 12 in HA-group, 22 in LA-group) averaged 48.6 (+12.0) years of age and were primarily Caucasian (97%) and female (72.2%). The mean Fagerstrom score was 5.0 (+2.3). Overall, one week into cessation (T1 to T2) there was significant worsening in SCQoLQ anxiety ($71.5 + 25.1$ to $61.1 + 26.0$, $p = 0.04$) and cognitive-functioning ($72.2 + 20.4$ to $61.3 + 23.9$, $p = 0.02$) scores and improved self-control ($46.5 + 22.2$ to $5.1 + 18.5$, $p = 0.001$) and SF-36 general health ($65.2 + 18.4$ to $70.5 + 16.9$, $p = 0.01$). At T1, all LA-group HQL scores were higher than HA-group scores, significantly for sleep, cognitive-functioning, anxiety, and SF-36 role-emotional and mental-health. Between T1 and T2 there was significant decline in sleep, cognitive-function, and anxiety and improved self-control in the LA-group; the HA-group had significant improvement in self-control and SF-36 general-health, but no significant changes in other scores. All SCQoLQ scores at T2 for LA were higher than either the T1 or T2 SCQoLQ scores for the HA. **CONCLUSIONS:** Generally, HQL changes one-week into a smoking cessation attempt. Smokers with higher addiction have lower HQL when they begin their cessation attempt, while smokers with lower addiction have greater change in their HQL.

PCV38

HEALTH-RELATED QUALITY OF LIFE IN AN ACUTE CORONARY SYNDROME POPULATION IS AFFECTED BY DEPRESSION TREATMENT ADEQUACY

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OBJECTIVES: 1) To determine the prevalence of depression symptoms and to describe antidepressant treatment in a population with a history of ACS, and 2) To describe the relationship of depression treatment adequacy and health-related quality of life (HRQL) controlling for patient, treatment and disease characteristics. **METHODS:** All ACS-diagnosed patients discharged from a university-affiliated hospital during a 3-year period were mailed a survey that included the SF-8, EQ-5D and other self-reported measures of disease and treatment (e.g. physical functioning, comorbidity, medication compliance, perceived cardiac severity). Patients were categorized based on self-report of depressive symptoms and antidepressant medication. Adjusted mean HRQL measures were determined by least square mean analysis controlling for independent variables. **RESULTS:** Of 1217 patients, 490 (40.3%) responded. Respondents averaged 65.2 (± 11.3) years of age; 71% male; 92% Caucasian; 64% with MI history; 17% had their most recent cardiac event within 6 months. No depressive symptoms and no depression treatment (without depression) were reported by 59.8%; 27.6% reported untreated depressive symptoms (untreated); 8.6% reported depressive symptoms and antidepressant medication (undertreated); and 4.1% reported no symptoms and antidepressant medication (adequately treated). Adjusted mean SF-8 Mental Component Summary (MCS-8) scores were 52.8, 52.5, 42.8, and 40.2 for patients without depression, adequately treated, untreated, and undertreated respectively ($p < 0.0001$ for all pairwise comparisons except for patients without depression vs. adequately treated and untreated vs. undertreated). The only other significant pairwise HRQL comparison was between the adjusted mean general health VAS scores for nondepressed and